PERSONAL SERVICES CONTRACT

l. Parties. This is a contract for personal services between the State of Vermont, Department of Vermont Health Access (hereafter called "State"), and Community Health Accountable Care, LLC, with a principal place of business in Montpelier, Vermont (hereafter called "Contractor" or "ACO"). The Contractor's form of business organization is a limited liability company. The Contractor's local address is 61 Elm Street, Montpelier Vermont, 05602. It is the Contractor's responsibility to contact the Vermont Department of Taxes to determine if, by law, the Contractor is required to have a Vermont Department of Taxes Business Account Number.

2. Subject Matter. The subject matter of this contract is personal services generally on the subject of accountability for cost and quality of health services. Detailed services to be provided by the Contractor are described in Attachment A.

3. Maximum Amount. In consideration of the services to be performed by Contractor, the State agrees to pay Contractor, in accordance with the payment provisions specified in Attachment B, a sum not to exceed 10% of total actual expenditures in the performance year calculated in **Section IV (F)(1).**

4. Contract Term. The period of Contractor's performance shall begin on March 14, 2014 and end on March 13, 2016.

5. Prior Approvals. If approval by the Attorney General's Office or the Secretary of Administration is required, (under current law, bulletins, and interpretations), neither this contract nor any amendment to it is binding until it has been approved by either or both such persons.

Approval by the Attorney General's Office is required.
Approval by the Secretary of Administration is required.

6. Amendment. No changes, modifications, or amendments in the terms and conditions of this contract shall be effective unless reduced to writing, numbered and signed by the duly authorized representative of the State and Contractor.

7. Cancellation. This contract may be cancelled by either party by giving written notice at least 30 days in advance. Notwithstanding this provision, if a governmental agency with due authority determines that a program or facility operated by the Contractor, wherein services authorized under this contract are provided, is not in compliance with State and Federal law or is operating with deficiencies the State may terminate this contract immediately and notify the Contractor accordingly. Also, in the event that federal funds supporting this contract become unavailable or are reduced, the State may cancel this contract with no obligation to pay the Contractor from State revenues

8. Attachments. This contract consists of (51) pages including the following attachments, which are incorporated herein:

Attachment A - Specifications of Work to be Performed
Attachment B - Payment Provisions
Attachment C - Customary State Contract provisions
Attachment D - Modifications of Insurance
Attachment E - Business Associate Agreement
Attachment F - Customary Contract Provisions of the Agency of Human Services
Attachment G -Appendix I Department of Vermont Health Access
Request for Approval to Subcontract
Attachment H - Federally Qualified Health Center (FQHC)/Rural Health Center (RHC)
Adjustment
Attachment I - Services Considered Ineligible Individual Attribution Methodology, Step 2

The order of precedence of documents shall be as follows:

1). This document
2). Attachment D (if any)
3). Attachment C
4). Attachment A
5). Attachment B
6). Attachment E (if any)
7). Attachment F
8). Attachment G
9). Attachment H

WE THE UNDERSIGNED PARTIES AGREE TO BE BOUND BY THIS CONTRACT.

BY THE STATE OF VERMONT:

E-SIGNED by Mark Larson on 2014-03-14 20:59:05 GMT — March 14, 2014

MARK LARSON, COMMISSIONER — DATE
312 HURRICANE LANE, SUITE 201
WILLISTON, VT 05495-2087
PHONE: 802-879-5901
EMAIL: MARK.LARSON@STATE.VT.US

BY THE CONTRACTOR:

E-SIGNED by Lori Real on 2014-03-14 20:44:50 GMT — March 14, 2014

LORI H. REAL, CHAC INTERIM ADMINISTRATOR, DATE
525 CLINTON STREET
BOW, NH 03304
PHONE: 603-228-2830 X114
EMAIL: IREAL@BISTATEPCA.ORG

ATTACHMENT A
SCOPE OF WORK

1. Definitions

As used in this Agreement, the following terms shall have the meaning indicated. Further, terms defined in the VMSSP Standards set forth in as Exhibit 1 attached hereto and incorporated herein by reference, shall have the meaning ascribed in the VMSSP Standards.

1.1 *Accountable Care Organization (ACO) or Contractor* means the party to this Agreement that is a legal entity comprised of providers of Health Care Services that agree to work together to be accountable for the quality, cost and overall care of Attributed Lives.

1.2 *ACO Participant* means an individual or group of ACO providers/suppliers that is identified by a Medicaid -enrolled provider number, that alone or together with one or more other ACO participants comprises the ACO, and that is included on the list of ACO participants required to be submitted as part of the program. An ACO participant bills Medicaid for services through its Medicaid enrolled provider number.

1.3 *Agency of Human Services* means the Agency defined by 3 V.S.A. § 3001 and created by 3 V.S.A § 3002 as amended.

1.4 *ACO Provider/Supplier* means an individual or entity that is a Medicaid provider or supplier enrolled in Medicaid and bills for services under an ACO Participant Medicaid provider number. For example, a large group practice may qualify as an ACO Participant. A Medicaid enrolled physician billing under the practice Medicaid provider number would be an ACO Provider/Supplier.

1.5 *Attributed Life/Lives* means Beneficiaries who are assigned to an ACO in accordance with the VMSSP Standards ("VMSSP Standards") (Exhibit 1) and whose cost of care is calculated in the Shared Savings calculation performed under those Standards.

1.6 *Beneficiary* means Medicaid eligible and enrolled persons who meet the criteria of the VMSSP Standards for Attributed Lives (Exhibit 1).

1.7 *Blueprint for Health or Blueprint* means the State of Vermont's program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.

1.8 *CMS-HCC (Hierarchical Condition Categories) prospective risk adjustment model* means the community version of the risk-adjustment methodology developed by the Centers for Medicare and Medicaid Services that is most recent at the time of calculation.

1.9 *Current Procedural Terminology (CPT) Codes* means a system of codes developed by the American Medical Association for standardizing the terminology and coding used to describe medical services and procedures.

1.10 *DVHA* means the Department of Vermont Health Access, a Department of the Agency of Human Services and an instrumentality of the State of Vermont. DVHA may be referred to as the "State" in this Agreement.

1.11 *HEDIS* means the Healthcare Effectiveness Data and Information Set.

1.12 *Health Care Provider or Provider* means (a) a health care facility, defined as all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, prevention, treatment, inpatient or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered, excluding any facility operated by religious groups relying solely on spiritual means through prayer or healing, but including all institutions included in 18 V.S.A. §9432 (except health maintenance organizations); and (b) a person, partnership or corporation, other than a facility or institution, licensed or certified or authorized by law to provider professional Health Care Services to an individual during that individual's health care treatment or confinement.

1.13 *Health Care Services* means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

1.14 *Medicaid* means the Vermont Medicaid program.

1.15 *Minimum Savings Rate* means a percentage of the benchmark that ACO savings must exceed in order to qualify for shared savings.

1.16 *Performance Year* means the twelve 12 month period beginning on January 1 and ending December 31 of each year during the Agreement's term.

1.17 *Primary Care Practice* means individual or group of physicians, nurse practitioners, physician assistants or a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) that are 1) enrolled with Medicaid and 2) have at least one provider whose rendering Medicaid provider number is identified with a provider specialty of internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, or naturopathic practitioner.

1.18 *Quality Measures or Performance Measures* means the measures defined by the VMSSP Standards, to assess the quality of care furnished by an ACO, such as measures of clinical processes and outcomes, patient and, where practicable, caregiver experience of care and utilization.

1.19 *Shared Savings* means the portion of the difference between Actual Expenditures that are less than Expected Expenditures in a Performance Year that ACO is eligible to receive as payment according to the formulas and procedures set forth in the VMSSP Standards.

1.20 *Vermont Chronic Care Initiative (VCCI)* means a program for Medicaid beneficiaries managed by DVHA to coordinate the care for beneficiaries presenting complex healthcare needs.

1.21 *Vermont Health Care Innovation Project (VHCIP)* means the collective operational and governance structures with oversight of payment reform activities; co-led by the GMCB and DVHA, and funded by the Center for Medicare and Medicaid Innovation, State Innovation Model grant. The structure includes seven work groups, a Steering Committee and a Core Team. The VHCIP serves to coordinate and make decisions about quality improvement efforts to control growth in health care costs, improve health care, and improve the health of Vermont's population.

1.22 *VMSSP* means the Vermont Medicaid Shared Savings Program Pilot for Accountable Care Organizations.

1.23 *VMSSP Standards* means the set of written standards and guidelines for the Medicaid Shared Savings Pilot Program for accountable care organizations developed by a multi-stakeholder working group and approved by the GMCB.

2. ACO/Contractor Requirements

2.1 Contractor will meet the requirements of each of the VMSSP Standards that are applicable to ACO/Contractor, attached as Exhibit 1.

2.2 Contractor will require, through Participation Agreements, or other contractual arrangements, with ACO Participants that those providers are enrolled with DVHA.

2.3 Contractor will monitor the quality of care provided to Attributed Lives; promote evidence based medicine and coordinate care for Attributed Lives.

2.4 Contractor will, to the extent permitted by privacy and other laws, receive and synthesize data from the State and other sources via electronic processes and use it to identify opportunities for beneficiary engagement and/or to stratify its population to determine appropriate care models intended to improve outcomes.

2.5 Contractor will designate a representative available to the State to address its concerns and needs and to participate in a reasonable number of regularly scheduled meetings with the State, to occur at least quarterly.

2.6 Contractor will complete the University of California at Berkley "Safety Net Accountable Care Organization (ACO): Readiness Assessment Tool" in the first quarter of each Performance Year.

3. DVHA/State Participation Obligations

3.1 DVHA will meet the requirements of each of the VMSSP Standards, attached as Exhibit 1 and made a part hereof, that is applicable to DVHA.

3.2 DVHA will pay to Contractor any earned Shared Savings due to Contractor in accordance with VMSSP Standards and this Agreement.

4. Program Requirements

4.1 Contractor will provide Beneficiary disclosure and opt-out notices in accordance with the procedures set forth below in order to:
1) ensure that the Beneficiary has been notified that their provider is a participant in VMSSP and 2) allow the Beneficiary to opt-out of the sharing of their medical claims data between the State and the Contractor. The intention is for each Beneficiary to receive one notice during the course of his/her attribution to the ACO; initial notices will be sent to Beneficiaries at the beginning of this Program, thereafter, notices to newly attributed Beneficiaries will be sent quarterly so long as the State has provided the Contractor with updated Beneficiary lists.

4.1.1 Contractor is responsible for notification to Beneficiaries that will provide the Beneficiary with: (1) notice of their Health Care Provider's participation in the VMSSP: (2) appropriate disclosure of the use of his/her claims data; and (3) the ability to opt-out of sharing his/her claims data if desired. The notification should be sent to initially Attributed Lives in the first quarter of 2014 if beneficiary lists have been provided to Contractor. Notifications to subsequently Attributed Lives should be sent quarterly or as new beneficiary lists become available.

4.1.2 Contractor must provide Beneficiaries with the written notification described in Section 4.1.1 by mail and/or in person prior to, during or following the Beneficiary's visit to a participating Primary Care Practice, so long as Contractor has received notice of the assignment via a Beneficiary list. Contractor may use electronic communication if a Beneficiary agrees to this method of communication. The language used in the notification must reflect the appropriate literacy level and/or a diversity of languages represented within the Medicaid population. The form of notification will be approved by the State and the notification process will include:

a. Contractor will track and report to the State on the notification and method of notification;
b. Contractor will identify to DVHA any Beneficiaries who seek to opt-out of sharing their claims data by providing DVHA with a list of such Beneficiaries on a monthly basis by uploading the list in a form specified by DVHA, to a secured site identified by DVHA; and .
c. DVHA will record these Beneficiaries and exclude them from the claims data extracts described in Exhibit 1, Section VIII, Data Use.

4.2 Contractor will, no later than 60 days after the beginning of Performance Years 2 and 3, and at such time as mutually agreed for Performance Year 1, update the ACO Participant and, ACO Provider/Supplier reporting spreadsheets and submit them to the State. The Parties expect that administrative rules surrounding this process will be enacted, but until such time as they are, agree to follow the protocol set forth herein.

4.2.1 This submission must include any new forms of ACO participant agreements and identify any material changes to previously submitted forms of ACO Participant agreements. Submissions must be received by the State no later than April 10 of a given Performance Year. Contractor shall submit any subsequent amendments to the content of the

reporting spreadsheets no later than ten (10) business days after the beginning of each calendar month.

4.2.2 The Contractor must submit any material changes to the form of the ACO Participant Agreements to the State for evaluation by State only to ensure that the Agreements have the required regulatory elements: (a) a requirement that ACO Participants comply with the requirements of the VMSSP; (b) a description of the ACO Participant's rights and obligations in and representation by the ACO, including how the opportunity to share in savings or other financial arrangements will encourage ACO Participants to adhere to the quality assurance and improvement program and evidence-based clinical guidelines and should include language giving ACO the authority to terminate and ACO Participant for its non-compliance with the requirements of the VMSSP; and (c) a statement that Beneficiaries are free to use their providers of choice, consistent with their benefits.

5. Dispute Resolution

5.1 Progressive Dispute Resolution. Disputes between the ACO and DVHA related to or arising out of the terms of this Agreement shall be submitted to the dispute resolution process described herein before any Party pursues a remedy from a third party.

a. The issue in dispute will be referred to the ACO Program Director for DVHA, and the individual referred to in Paragraph 2.5 of Attachment A of this Agreement for the Contractor, or their respective designees. Each representative shall consult with the managerial or directorial staff who are routinely tasked with oversight of work concerning the subject matter of the issue in dispute. The Parties shall gather the information they need to evaluate the issue in dispute and will have fourteen (14) days from the date the issue is referred to resolve the dispute.

b. If the program directors, or individuals referred to in Section 5.1.a, have not resolved the issue in dispute within fourteen (14) days, the issue will be referred to the Commissioner of the Department of Vermont Health Access, or his/her designee, for the State, and to the Chief Executive Officer of the ACO, or his/her designee, for the ACO. The parties shall gather the information they need to evaluate the issue in dispute and will have thirty (30) days from the date the issue is referred to resolve the dispute.

c. If the issue in dispute is not resolved by the Senior Leaders, or the individuals referred to in Section 5.1.b, within thirty days from the date the issue is referred, ACO or Payer may bring an action in any court with jurisdiction.

6. Changes During the Agreement Term

6.1 This Agreement, including Exhibits, and attachments, may only be amended or modified in writing as mutually agreed to by the Parties.

6.2 The Parties intend, at a minimum, to amend this Agreement for Performance Years 2 and 3 to maintain its consistency with any changes to relevant standards adopted by the

Vermont Health Care Innovation Project (VHCIP). Any such amendments must be mutually agreed to by the Parties in writing.

6.3 Changes to the calculations for determination of Shared Savings will be subject to a determination of materiality threshold. Should the changes exceed this threshold, then the parties will follow the dispute resolution process described in Section 5. The materiality threshold is defined as a change affecting more than 15% of either beneficiaries or expenditures in any of the four eligibility categories for a given benchmark or performance year (ABD Adult, General Adult, BD Child, General Child).

6.3.1 The State will issue written guidance concerning whether changes in provider coding patterns have had a material impact on medical spending. The Parties agree that if the State determines that there has been an impact, they will refer to VHCIP for advice as to how such impact should be addressed in this Agreement. The Parties agree that their intent, if confronted with such a situation, is to amend, in writing, this Agreement in a mutually agreeable manner consistent with the advice received from VHCIP, if that is reasonably possible.

6.3.2 .At the request of the Contractor, the State will reconsider Expected Spending if unanticipated events, such as macro-economic or environmental events, occur that would reasonably be expected to have significant, unanticipated impact upon medical expenses. The State will make reasonable adjustment(s) to Expected Spending if such is the case. Whether an adjustment is reasonable shall be a matter for the sole discretion of the State; however a disagreement about such an adjustment will constitute a basis for termination of this Agreement by ACO with the right to receive Shared Savings through the Performance Year of Termination as described by Section 7.

7. Effect of Termination

The provisions of this Paragraph 7, shall apply notwithstanding anything to the contrary in this Agreement, and with the specific intent to supersede the Personal Services Contract pages of this Agreement and all other provisions of all other Attachments**,**

7.1 In the event of termination of this Agreement for any reason, after the first Performance Year, ACO shall be entitled to, and DVHA shall pay, all Shared Savings earned for any Performance Year prior to termination, regardless of whether they have been paid as of the date of termination.

7.2 If the Agreement is terminated by the State for any reason other than Contractor's material breach and if Contractor has met the minimum Quality Measure scores for the time during which it participated and all other requirements for participation during that time period, including but not limited to number of Attributed Lives, Contractor shall be entitled to and DVHA shall pay all Shared Savings calculated in accordance with the following guidelines:

7.2.1 When termination occurs at any time during a Performance Year, Contractor shall be entitled to a proportion of shared savings commensurate with the number of full months for which the program was active, according to the formula: [Number of Active

Months/12] * [Total Annual Savings of ACO in Performance Year], in addition to any unpaid Shared Saving from the prior Performance Year.

7.2.2 Calculations and payments under this section will be made according to the same schedule and requirements as for Shared Savings calculated under this Agreement generally. This means that calculations are made retrospectively at the end of the Performance Year and are subject to all the requirements of the Performance Year in which the termination occurred. In order to realize the payment of Shared Savings under this provision, Contractor must report (if applicable) any performance data, and must meet quality thresholds established for that Performance Year for the period of time before termination.

7.2.3 For termination effective in the middle of a month (i.e. between the first and last days of a month), no credit will be given for any partial month; rather the numerator, Number of Active Months in 7.2.1, will be the number of months where the contract was in force from the first day of the month through the last day of that month.

7.3 Should the Contractor terminate without cause before July 1 of a Performance Year, Contractor will forfeit any Shared Savings accrued during that Performance Year.

7.4 Termination by either party will be communicated through certified first class mail, with return receipt requested, to:

7.4.1 The Commissioner of DVHA, if the Agreement is terminated by the Contractor, or;

7.4.2 The Chief Executive Officer of the Contractor, if the Agreement is terminated by the State.

7.5 Termination notices that do not specify an effective date, will be effective twenty (20) days from the date of the notice, unless otherwise mutually agreed by the Parties.

7.6 Notwithstanding Sections 7.1 and 7.2, in the event that this Agreement is terminated by the State due wholly to failure of federal financial participation funds to match state share of Shared Savings, the matter will be referred to the process described in Sections 4A and 4B of Attachment C, and Sections 7A and 7B of the Personal Services Contract, as described in Attachment D.

Exhibit 1
Medicaid Shared Savings ACO Program Standards (VMSSP Standards)

I. Financial Stability

A. The parties intend to protect the Contractor from the assumption of "insurance risk" (the risk of whether a patient will develop an expensive health condition) when contracting with private and public payers so that the Contractor can focus on management of performance risk (the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition). To that end, the Contractor will not be responsible financially if Actual Total Cost of Care (TCOC) exceeds Expected TCOC under this Agreement (i.e., no downside risk).

B. If requested by the State, the Contractor will furnish financial reports regarding risk performance, with report formats defined by the State.

C. In order to continue to be eligible to participate in the Medicaid Shared Savings Program, the Contractor shall maintain responsibility for a minimum number of attributed lives, as defined in Section 1.5 of Attachment A, and Sections III and IV(A) of Exhibit 1 of this Agreement.

D. A Risk Mitigation plan is not required**.**

II. Contractor Governance

A. The Contractor must maintain an identifiable governing body that has responsibility for oversight and strategic direction, holding the Contractor's management accountable for its activities.

B. The Contractor must identify its board members, define their roles and describe the responsibilities of the board in writing to the State.

D. The Contractor's governing body must have a transparent governing process which includes the following:

1. Publishing the names and contact information for the governing body members, for example, on a website;
2. Devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of the Contractor's activities;
3. Making meeting minutes available to the Contractor's provider network upon request, and
4. Post summaries of Contractor activities provided to the Contractor's consumer advisory board on the ACO's website.

E. The Contractor's governing body members shall have a fiduciary duty to the ACO and act consistently with that duty.

F. At least 75 percent voting membership of the Contractor's governing body must be held by or represent Contractor participants or provide for meaningful involvement of Contractor participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

1. Has a signed Participant Agreement;
2. Has programs designed to improve quality, patient experience, and manage costs; and
3. Is eligible to receive shared savings distributions based on the distribution rules of the Contractor or participate in alternative financial incentive programs as agreed to by the Contractor and its participants.
4. A "participant" does not need to have lives attributed to the Contractor to be considered a participant.
5. Of the 75% participant membership required on governing bodies:
    a. At least one seat must be held by a participant representative of the mental health and substance abuse community of providers; and
    b. At least one seat must be held by a participant representative of the post-acute care (such as home health or skilled nursing facilities) or long term care services and supports community of providers.
    c. Institutional and home-based long-term care providers, sub-specialty providers, mental health providers and substance abuse treatment providers are strongly encouraged to participate on ACO clinical advisory boards. This shall not be construed to create a right to participate or to be represented.
    d. It is also strongly encouraged that ACO participant membership serving all ages of Medicaid beneficiaries (pediatric and geriatric) be represented in governance and in clinical advisory roles. This shall not be construed to create a right to participate or to be represented.

G. The Contractor's governing body must include at least one consumer member who is a Medicaid beneficiary. Regardless of the number of payers with which the Contractor participates, there must be at least two consumer members on the Contractor governing body. Consumer members shall have some prior personal, volunteer, or professional experience in advocating for consumers on health care issues. The Contractor's governing board shall consult with advocacy groups and organizational staff in the recruitment process for the consumer member. The Contractor shall not be found to be in non-conformance with this provision if the Contractor has in good faith recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

H. The Contractor must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including but not limited to a consumer advisory board with membership drawn from the community served by the Contractor, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of the Contractor's management and the governing body must regularly attend consumer advisory board meetings and report back to the Contractor's governing body following each meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

III. Medicaid Patient Eligibility Requirements and Patient Attribution

A. Eligible Populations

The following population groups are eligible to be considered as attributed lives:

1. Aged, Blind or Disabled (ABD) Adult: Individuals who are 18 years of age or older who are aged, blind or disabled and who are not dually eligible for Medicare.
2. General Adult: Parents/caretaker relatives of minor children including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance; as well as adults with incomes below 133% of the Federal Poverty Level ("FPL") are assigned here. This could also include former VHAP, Catamount, ESIA, or previously uninsured individuals.
3. Blind or Disabled (BD) Child: Individuals who are under 21 years of age who are aged, blind or disabled and who are not dually eligible for Medicare.
4. General Child: Children under age 21 who are eligible for cash assistance; as well as children up to age 18 who were previously uninsured, living in families up to 300% FPL, and who are not otherwise classified under BD Child.

B. Excluded Populations

The following populations are excluded from being considered as attributed lives:

1. Individuals who are dually eligible for Medicare and Medicaid;
2. Individuals who have third party liability coverage;
3. Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and
4. Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

C. Enrollment Requirements

Individuals must be enrolled at least ten non-consecutive months in the calendar year in any aid category across all four population groups. If an individual transitioned from one population group to another within the calendar year (e.g., from General Child to BD Child), then all of the member's months and expenditures are assigned to the population group where the member was enrolled last in the calendar year. Individuals may not be split across the four population groups within a year; however, an individual may appear in multiple population groups across the three baseline years.

D. Attribution Methodology

The State or its designee will conduct attribution monthly. The details of the attribution reports are described in the Data Use Standards, Attachment A, Exhibit 1, Section VIII (B) of this Agreement.

1. Attribution Step 1: Determine all Medicaid beneficiaries who were enrolled for at least 10 months in the study year across any of the four enrollment categories. Assign the beneficiary to the enrollment category where he/she appeared last in the study year.

2. Attribution Step 2: Claims for eligible members are identified for the presence of qualifying CPT Codes (refer to Attachment I) in the calendar year for primary care providers enrolled with Medicaid. The provider specialty must be internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, or naturopathic medicine. In addition to physicians, the primary care provider may be a nurse practitioner, physician assistant, or a provider in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

3. Attribution Step 3: For eligible beneficiaries not attributed in Step 2, assign the beneficiary to his/her primary care provider that he/she selected or was auto-assigned to in the study year. If the beneficiary changed primary care provider selection during the year, then the beneficiary is assigned to the primary care provider which he/she was assigned to last in the year.

4. Attribution is done at the rendering provider level; any ACO Participant that includes at least one ACO Provider/Supplier with Attributed Lives must have an exclusive Participant relationship with one ACO. ACO Participants who do not have lives attributed, can participate in multiple ACOs.

E. Patient Freedom of Choice

Beneficiaries will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. Calculation of Contractor Financial Performance and Shared Savings

A. Summary of Model Specifications

1. Program eligibility requires a minimum number of 5,000 attributed beneficiaries. The maximum savings rate is fifty percent (50%).

2. The Contractors may elect to pursue an optional methodology that increases the maximum savings rate beginning on January 1, 2015. The standards shall remain as set forth in this document for Contractors electing to pursue the alternative methodology. The alternative methodology would increase the maximum sharing rate of 50% for the Contractor by 10% to 60% if the Contractor elects to be accountable for additional non-core service expenditures in the Total Cost of Care (TCOC) as defined by the State. The State will notify the Contractor in writing of which non-core service expenditures will be required no later than October 1, 2014. The Contractor would elect the optional track in writing no later than November 1, 2014.

3. The Contractors will be required to be accountable for additional non-core service expenditures in the Total Cost of Care (TCOC) calculation as defined by the State in 2016. If the Contractor elected to participate in the option described in the paragraph above, the Contractor will continue to receive the additional 10% addition to the maximum sharing rate of 50% (or 60%). The State will notify the Contractor in writing of which non-core service expenditures will be required no later than July 1, 2015.

B. Core Service Expenditures

Core Service expenditures include: inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health center, chiropractor, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility.

C. Non-Core Service Expenditures

1. Non-Core Service expenditures include: personal care, pharmacy, dental, non-emergency transportation, services administered by the VT Department of Mental Health through Designated Agencies and Specialized Service Agencies, services administered by the VT Division of Alcohol and Drug Abuse Programs, services administered by the VT Department of Disabilities, Aging and Independent Living, services administered by the VT Department for Children and Families and services administered by the Vermont Department of Education.

2. Non-Core Service expenditures also include supplemental, lump sum disproportionate share payments and medical education payments as well as quality incentive payments made outside of the claims system.

D. Calculation of the Expected Total Cost of Care (TCOC)
In April following the end of a performance year (PY), the State or its designee will calculate an interim Expected TCOC. In July or August, the State or its designee will calculate the final Actual TCOC for use in the calculation of savings. The State or its designee shall calculate the Expected TCOC using the following steps:

1. Attribute beneficiaries in each of three historic calendar years (the "benchmark years") using the attribution methodology described in Attachment A, Exhibit 1, Section III of this agreement.
   a. For 2014, calendar years (CYs) 2010, 2011 and 2012 will be benchmark years.
   b. For 2015, CYs 2011, 2012, 2013 will be benchmark years.
   c. For 2016, CYs 2012, 2013, 2014 will be benchmark years.

2. Identify expenditures using the allowed amount value on claims data for all Core Services for each attributed member within a calendar year.

3. Re-price core service expenditures to base year.
   a. Base Years
      i. For 2014, base year is 2013.
      ii. For 2015, base year is 2014.
      iii. For 2016, base year is 2015.
   b. Inpatient hospital, outpatient hospital and professional services are re-priced.
   c. FQHC and RHC encounter rates are re-priced. (Attachment G).

d. If determined to be material, adjust for other changes in utilization. If additional changes in utilization are determined to meet the determination of materiality threshold defined in Section III.D.4, adjustments will be applied accordingly.

e. For all other services, the allowed amounts reported on the claims are used to sum expenditures.

4. Use the CMS-HCC (Hierarchical Condition Categories) prospective risk adjustment model to calculate member risk scores; apply a risk adjustment factor to account for changes in the health status of the population attributed in each of the benchmark years.

5. Determine a Cumulative Average Growth Rate (CAGR) is used for each of the four enrollment categories' to calculate total average per member per month (PMPM) value.

6. Trend the PMPM forward two full years to project a total average PMPM in the performance year (PY).

7. For PY1, the PMPM calculated in Step 6 (above) will be inflated to account for the November 1, 2013 rate increase which will be in effect in CY 2014 (PY1). PY2 and PY3 adjustments, if necessary, will be made to account for additional rate increases.

8. Calculate an annualized value for each beneficiary so that each beneficiary has a per member per year (PMPY) expenditure value for comparison purposes.

9. Truncate annualized expenditures at the 99th percentile within each of the four enrollment categories. In other words, if a particular beneficiary incurred expenditures above the 99th percentile value within the enrollment category, this beneficiary's expenditures are truncated so that their total expenditures in the calculation will equal the value set at the 99th percentile.

10. Divide the trended, rate change-adjusted, annualized, and truncated expenditures by annualized member months to compute the Expected PMPM TCOC for each of the four enrollment categories.

E. Retrospective Calculation of the Actual Total Cost of Care (TCOC)

In April following the end of a performance year (PY), the State or its designee will calculate an interim Actual TCOC . In July-August, the State or its designee will calculate the final Actual TCOC for use in the calculation of savings. The TCOC will be calculated using Medicaid claims data and enrollment files. TCOC shall be defined to include all paid claims for the Contractor-responsible core services as defined in Section IV(B). Actual TCOC will be calculated by:

1. Running the attribution algorithm as described in Section III (D) of this Agreement using the claims and enrollment data for the performance year (PY).

2. Calculate per member per year expenditures for each attributed beneficiary, imputing an annualized value for those beneficiaries enrolled only 10 or 11 months and not 12 months. The formula for annualizing is the same as that described in Section IV (D)(8) this Agreement.

3. Re-price the FQHC/RHC encounter rates as described in Appendix G.

4. Use the CMS-HCC prospective risk adjustment model to calculate risk scores for each of the four enrollment categories. If the risk scores within an enrollment category differ between the performance year and the benchmark years, then a risk adjustment factor will be applied to the performance year expenditures to align them with the risk scores in the benchmark years.

5. Expenditures are truncated at the 99th percentile for each enrollment category in the same manner as was described in Section IV(D)(9) of this Agreement.

6. The truncated expenditures are then divided by annualized member months to compute the Actual PMPM TCOC for each of the four enrollment categories.

7. A single weighted Actual PMPM TCOC is computed by weighting each of the four enrollment category Actual PMPM TCOCs by the annualized member months.

8. The same weighting of annualized member months in the performance year is applied to the four enrollment category Expected PMPM TCOCs from Section IV (D)(10) of this Agreement to derive a single weighted Expected PMPM TCOC.

9. Calculate Total Member Months (TMM). TMM is the sum of the actual, non-annualized number of member months for final attributed beneficiaries during the PY.

F. Aggregate Difference in Expected and Actual Expenditures (Savings Calculation)
Total savings will be calculated by:

1. Multiplying the Actual PMPM calculated in Section IV(E)(7) by TMM from Section IV(E)(9) of this Agreement.

2. Multiplying the Expected PMPM calculated in Section IV(E)(8) by TMM from Section IV(E)(9) of this Agreement.

3. Subtracting #2 from #1 above.

G. Total Eligible Savings Amount

1. Based on the calculation in Section IV(F) of this Agreement, the State or its designee will determine if the Actual Cost of Care is less than the Expected Cost of Care for the Performance Year.

2. The State will then determine whether or not the savings are greater than or equal to the minimum savings rate (MSR) based on the number of beneficiaries attributed to the Contractor in that performance year. The MSR shall serve as the threshold necessary to share in savings.

a. The State or its designee will calculate the MSR based on the following table and formula:

Minimum Savings Rate by Number of Assigned Beneficiaries

Number of Beneficiaries	MSR Low End	MSR High End
5,000 – 5,999	3.9%	3.6%
6,000 – 6,999	3.6%	3.4%
7,000 – 7,999	3.45	3.2%
8,000 – 8,999	3.2%	3.1%
9,000 – 9,999	3.1%	3.0%
10,000 – 14,999	3.0%	2.7%
15,000 – 19,999	2.7%	2.5%
20,000 – 49,999	2.5%	2.2%
50,000 – 59,999	2.2%	2.0%
60,000 +	2.0%	2.0%

b. MSRs which are in between the stated endpoints are calculated using the following equation, which is a weighted average of the stated endpoints:
MSR High End % x (Number of Beneficiaries High End – Number of Attributed Beneficiaries) / (Number of Beneficiaries High End – Number of Beneficiaries Low End) + MSR Low End % x (Number of Attributed Beneficiaries – Number of Beneficiaries Low End) / (Number of Beneficiaries High End – Number of Beneficiaries Low End)

3. If total savings are greater than or equal to the MSR, then the Contractor will be eligible to share in the savings. If not, the Contractor will not be eligible to share in savings.

4. If MSR is met, the total eligible amount of shared savings will be calculated by multiplying the total savings by the maximum savings rate.

5. The final shared amount is subject to a cap equal to 10% of total actual expenditures in the performance year calculated in Section IV(F) of this Agreement.

6. The final sharing rate is equal to the product of the Contractor's quality score and the maximum sharing rate. Computation of the quality score is described in Attachment A, Exhibit 1, Section V of this Agreement.

V. Performance Measurement and Shared Savings

To be eligible for savings, the Contractor must first meet the quality performance threshold. If the threshold is met, a quality score will be calculated. The State or its designee will calculate the threshold and quality score and in so doing will sample only Beneficiaries who have been continuously enrolled for twelve (12) or more months.

The calculations are described in below.

A. Assignment of Scores to Core Payment Measures

1. Table 1 below summarizes the core payment measures and benchmarks used in the calculation. Points are assigned using the following methodology:

   a. One point is assigned to the national Medicaid HEDIS 25th percentile for each measure.
   b. Two points are assigned to the national Medicaid HEDIS 50th percentile for each measure.
   c. Three points are assigned to the national Medicaid HEDIS 75th percentile for each measure.

2. For measures where national Medicaid HEDIS benchmarks do not exist (Core-1 and Core-8 in Table 1), points are assigned using the following methodology: The State will calculate a Vermont Medicaid 2012 benchmark and assign 0, 2, or 3 points based on statistically significant decline, no statistically significant change, or statistically significant improvement, respectively. The benchmarks will be completed no later than April 30, 2014.

B. Requirements for Reporting Measures

Table 2 below summarizes the core reporting measures. These measures will not be used in the calculation but submission of these measures by the Contractor to the State is required, however, failure to report will not jeopardize Shared Savings or funding. The State also requires the reports to include an analysis of barriers, costs incurred related to reporting and a plan to mitigate those barriers where possible. Guidelines for the content and format of this analysis and plan will be provided by the State.

Table 1. Core Measures for Payment

#	**Measure**	**Data Source**	**2012 Benchmark**
Core-1	**Plan All-Cause Readmissions NQF #1768, NCQA** **(Average Adjusted Probability of Readmission)**	**Claims**	**National benchmark not available** **Vermont Medicaid Benchmark to be calculated**

Core-2	**Adolescent Well-Care Visits HEDIS AWC**	**Claims**	**Nat. 90th: 65.45 Nat. 75th: 57.07 Nat. 50th: 47.24 Nat. 25th: 41.72**
Core-3	**Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)**	**Claims**	**Nat. 90th: 88.84 Nat. 75th: 85.20 Nat. 50th: 82.36 Nat. 25th: 78.44**
Core-4	**Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH**	**Claims**	**Nat. 90th: 68.79 Nat. 75th: 54.64 Nat. 50th: 43.95 Nat. 25th: 30.91**
Core-5	**Initiation & Engagement of Alcohol and Other Drug Dependence Treatment a) Initiation, b) Engagement NQF #0004, NCQA HEDIS IET CMMI**	**Claims**	**Nat. 90th: 34.04 Nat. 75th: 29.64 Nat. 50th: 24.75 Nat. 25th: 20.59**
Core-6	**Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB**	**Claims**	**Nat. 90th: 35.45 Nat. 75th: 28.07 Nat. 50th: 22.14 Nat. 25th: 17.93**
Core-7	**Chlamydia Screening in Women NQF #0033, NCQA HEDIS CHL**	**Claims**	**Nat. 90th: 68.81 Nat. 75th: 63.72 Nat. 50th: 57.15 Nat. 25th: 50.97**
Core-8	**Developmental Screening in First 3 Years of Life NQF#1448**	**Claims**	**National benchmark not available Vermont Medicaid Benchmark to be calculated**
Core-9	**Depression Screening by 18 Years of Age NQF#1515**		**MEASURE NOT TO BE USED IN YEAR 1**

Table 2. Core Measures for Reporting

#	Measure	Data Source
Core-10	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	Claims
Core-11	Breast Cancer Screening	Claims
Core-12	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	Claims
Core-13	Appropriate Testing for Children with Pharyngitis	Claims
Core-20	Adult BMI Screening and Follow-Up	Clinical
Core-19	Screening for Clinical Depression and Follow-Up Plan	Clinical
Core-18	Colorectal Cancer Screening	Clinical
Core-16	Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use	Clinical
Core-17	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	Clinical
Core-14	Childhood Immunization Status	Clinical
Core-15	Pediatric Weight Assessment and Counseling	Clinical
Core-21	Access to Care Composite	Survey
Core-22	Communication Composite	Survey
Core-23	Shared Decision-Making Composite	Survey
Core-24	Self-Management Support Composite	Survey
Core-25	Comprehensiveness Composite	Survey
Core-26	Office Staff Composite	Survey
Core-27	Information Composite	Survey
Core-28	Coordination of Care Composite	Survey

Core-29	Specialist Care Composite	Survey

C. Calculation of Performance
The State or its designee will calculate the performance of the Contractor for the measures and assign points as described in Section V(A) of this Agreement. The State or its designee will also calculate the total number of points possible for the measures described in Section V(A) of this Agreement**.**

D. Threshold Calculation
The Contractor must earn 35% of eligible points in order to meet the minimum threshold for performance ("the gate"). If the Contractor is not able to meet the overall quality gate, then it will not be eligible for any shared savings.

E. Calculation of the Quality Score
If the Contractor meets the performance threshold ("the gate"), it may retain at least 75% of the savings for which it is eligible. The amount of eligible savings will vary based on the Contractor's quality score. The quality score will be equal to the Contractor's actual performance as determined in Table 3 based on calculations described in Section V of this Agreement**.**

Table 3. Quality Score

Percentage of available points	Quality Score
35%	75%
40%	80%
45%	85%
50%	90%
55%	95%
60%	100%

F. Final Calculation of Shared Savings Payments
The total eligible savings amount calculated in Section IV(G)(5) will be multiplied by quality score determined in Section V(E) of this Agreement**.** This represents the Contractor's share in the savings to be paid via the terms listed in Attachment B, Payment Provisions.

VI. Care Management Standards

A. The Contractor will maintain regular contact with Vermont Chronic Care Initiative (VCCI) to ensure that efforts around care management are well coordinated through regular and ad-hoc in-person and telephonic meetings; at minimum, the Contractor agrees to a meeting monthly but as frequently as both parties agree is needed.

B. The Contractor will maintain as needed contact with other Vermont Agency of Human Services (AHS) departments engaged in care management or care coordination activities particularly as it relates to federal mandates (e.g., Early Periodic Screening, Diagnosis, and Treatment) and vulnerable populations (e.g., Disabilities, Traumatic Brain Injury, Integrated Family Services). Examples of this contact will include but not be limited to: meetings (in-person and telephonic), educational outreach, partnering, launching or rolling out new or existing initiatives, and direct care coordination.

C. If requested, the Contractor will, no more frequently than annually and no sooner than 60 days from the request, participate with the State to create a written plan describing detailed approach to care management activities described above. Any AHS employee and/or contractor who provides care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS programs or procedures and with Medicaid's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO. Should there be a conflict between the ACO's Clinical Model or Care Model and AHS programs or procedures, AHS employees and contractors shall cooperate with and implement the Clinical Model or Care Model of the ACO for a mutually agreeable time frame. DVHA and AHS acknowledge that this cooperation is critical to ACO in order to meet the quality, patient experience and financial performance thresholds under this Agreement. In the event of a dispute regarding the Clinical Model or Care Model, the parties may invoke the Dispute Resolution process set forth in Section 5 of Attachment A.

VII. Payment Alignment

The parties share the objective of improving the likelihood that ACOs attain their cost and quality improvement goals by aligning payment incentives at the payer-ACO level to the individual clinician and facility level.

A. The performance incentives that are incorporated into the payment arrangements between the State and the Contractor should be appropriately reflected in those that the Contractor utilizes with participating providers. Annually, no later than the third quarter of each program year, the Contractor will share with the State their written plans for:

1. Aligning provider payment and compensation with Contractor performance incentives for cost and quality; and

2. Distributing any earned shared savings.

3. Specific to affiliated providers or incentive pool forms of compensation, the Contractor will provide detailed and specific plans for funding and distribution under these programs.

B. The State will support the Contractor by collaborating to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

VIII. Data Use

A. Program Reporting Requirements- Contractor to the State
The following tables summarize reporting requirements:

Report	***Details***	***Start Date***	***Frequency***	***Responsible Party***	***Receiving Party***	***Format***
Monthly provider changes within PCP practices for attribution. Other additions to participant, provider/supplier lists.	Additions and terminations by site, including site-specific information of providers practicing at multiple sites	As mutually agreeable to the parties	monthly	ACO	DVHA	Specified by State
Clinical data-based measures required for Year One Contractor may elect between the Sample method and the Electronic data method	Sample method: Contractors, the State or its designee will generate sample. Contractor will generate numerators and denominators and report to the State or its designee using report template. OR Electronic data method: The Contractor generates numerators and denominators for all practices with EHR capability to report one or more rates, and reports percentage of attributed lives represented by the practices reporting each measure.	Sample method: The State or its designee provide sample to Contractor by January 2015. Sample and electronic data methods: The Contractor report to the State or its designee by April 2015.	Annual	Contractor	Contractor and the State	VHCIPSpecified Format

B. Reports from the State to the Contractor
The following tables summarize reporting requirements.

Report	***Details***	***Start Date***	***Frequency***	***Responsible Party***	***Receiving Party***	***Format***
Patient attribution report - enrollment	Data file with list of patients that are attributed to a particular Contractor, with identification of Primary Care Physician	January 2014	monthly	The State or its designee	Contractor	State specified, includes HCC Scores
Patient attribution report - claims extract	Initial file to contain 12 months of incurred claims, including pharmacy, for attributed enrollees. Every month thereafter a file contained claims paid in the past month for currently attributed enrollees, and for the past 12 months for new enrollees	March 2014	monthly	The State or its designee	Contractor	VHCURES Format
If requested, Stratification of patients by risk score with supplemental information	The State's software	April 2014	quarterly	The State or its designee	Contractor	Format used by the State
If requested, Patient gaps in care	The State's gaps in care reports	Existing payer schedules	Existing payer schedules	The State or its designee	Contractor	Format used by the State

ATTACHMENT B
PAYMENT PROVISIONS

The maximum dollar amount payable under this Agreement is not intended as any form of a guaranteed amount. The Contractor will be paid for products or services actually performed as specified in Attachment A up to the maximum allowable amount specified in this Agreement. Payments against this contract will comply with the State's payment terms. The payment schedule for delivered products, or rates for services performed, and any additional reimbursements, are included in this attachment. The following provisions specifying payments are:

1. The State or its designee will calculate annually any amounts computed for Shared Savings six months after the end of the Performance Year. Payments will be distributed on or after two to six weeks after final reconciliation is completed no later than the last day of the August following the end of the Performance Year. The provisions of this section will survive termination of this Agreement.
2. No benefits or insurance will be reimbursed by the State.
3. Invoices should reference this contract number and be submitted to:

   Business Office, Contracting Unit
   Department of Vermont Health Access
   312 Hurricane Lane, Suite 201
   Williston, VT 054953

The total maximum amount payable under this contract shall not exceed 10% of total actual expenditures in the performance year calculated in **Section IV(F)(1)**.

ATTACHMENT C
CUSTOMARY PROVISIONS FOR CONTRACTS AND GRANTS

1. **Entire Agreement.** This Agreement, whether in the form of a Contract, State Funded Grant, or Federally Funded Grant, represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.

2. **Applicable Law.** This Agreement will be governed by the laws of the State of Vermont.

3. **Definitions:** For purposes of this Attachment, "Party" shall mean the Contractor, Grantee or Subrecipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement.

4. **Appropriations:** If appropriations are insufficient to support this Agreement, the State may cancel on a date agreed to by the parties or upon the expiration or reduction of existing appropriation authority. In the case that this Agreement is funded in whole or in part by federal or other non-State funds, and in the event those funds become unavailable or reduced, the State may suspend or cancel this Agreement immediately, and the State shall have no obligation to fund this Agreement from State revenues.

5. **No Employee Benefits For Party:** The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the state withhold any state or federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

6. **Independence, Liability:** The Party will act in an independent capacity and not as officers or employees of the State.

   The Party shall defend the State and its officers and employees against all claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit. The Party shall notify its insurance company and the State within 10 days of receiving any claim for damages, notice of claims, pre-claims, or service of judgments or claims, for any act or omissions in the performance of this Agreement.

   After a final judgment or settlement the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party.

The Party shall indemnify the State and its officers and employees in the event that the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party.

7. Insurance: Before commencing work on this Agreement the Party must provide certificates of insurance to show that the following minimum coverage is in effect. It is the responsibility of the Party to maintain current certificates of insurance on file with the state through the term of the Agreement. No warranty is made that the coverage and limits listed herein are adequate to cover and protect the interests of the Party for the Party's operations. These are solely minimums that have been established to protect the interests of the State.

Workers Compensation: With respect to all operations performed, the Party shall carry workers' compensation insurance in accordance with the laws of the State of Vermont.

General Liability and Property Damage: With respect to all operations performed under the Agreement, the Party shall carry general liability insurance having all major divisions of coverage including, but not limited to:
Premises - Operations
Products and Completed Operations
Personal Injury Liability
Contractual Liability

The policy shall be on an occurrence form and limits shall not be less than:

$1,000,000 Per Occurrence

$1,000,000 General Aggregate

$1,000,000 Products/Completed Operations Aggregate

$ 50,000 Fire/ Legal/Liability

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

Automotive Liability: The Party shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Agreement. Limits of coverage shall not be less than: $1,000,000 combined single limit.

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

Professional Liability*:** Before commencing work on this Agreement and throughout the term of this Agreement, the Party shall procure and maintain professional liability insurance for any and all services performed under this Agreement, with minimum coverage of ***$1,000,000 per occurrence, and ***$3,000,000*** aggregate.

8. Reliance by the State on Representations: All payments by the State under this Agreement will be made in reliance upon the accuracy of all prior representations by the Party, including but not limited to bills, invoices, progress reports and other proofs of work.

9. **Requirement to Have a Single Audit:** In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, the Subrecipient will complete the Subrecipient Annual Report annually within 45 days after its fiscal year end, informing the State of Vermont whether or not a single audit is required for the prior fiscal year. If a single audit is required, the Subrecipient will submit a copy of the audit report to the granting Party within 9 months. If a single audit is not required, only the Subrecipient Annual Report is required.

   A single audit is required if the subrecipient expends $500,000 or more in federal assistance during its fiscal year and must be conducted in accordance with OMB Circular A-133. The Subrecipient Annual Report is required to be submitted within 45 days, whether or not a single audit is required.

10. **Records Available for Audit:** The Party will maintain all books, documents, payroll papers, accounting records and other evidence pertaining to costs incurred under this agreement and make them available at reasonable times during the period of the Agreement and for three years thereafter for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved. The State, by any authorized representative, shall have the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed under this Agreement.

11. **Fair Employment Practices and Americans with Disabilities Act**: Party agrees to comply with the requirement of Title 21V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement. Party further agrees to include this provision in all subcontracts.

12. **Set Off**: The State may set off any sums which the Party owes the State against any sums due the Party under this Agreement; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.

13. **Taxes Due to the State**:

    a. Party understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.

    b. Party certifies under the pains and penalties of perjury that, as of the date the Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.

    c. Party understands that final payment under this Agreement may be withheld if the Commissioner of Taxes determines that the Party is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.

d. Party also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Party has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Party has no further legal recourse to contest the amounts due.

14. Child Support: (Applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date the Agreement is signed, he/she:

a. is not under any obligation to pay child support; or
b. is under such an obligation and is in good standing with respect to that obligation; or
c. has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.

Party makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Party is a resident of Vermont, Party makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

15. Sub-Agreements: Party shall not assign, subcontract or subgrant the performance of this Agreement or any portion thereof to any other Party without the prior written approval of the State. Party also agrees to include in subcontract or subgrant agreements a tax certification in accordance with paragraph 13 above.

Notwithstanding the foregoing, the State agrees that the Party may assign this agreement, including all of the Party's rights and obligations hereunder, to any successor in interest to the Party arising out of the sale of or reorganization of the Party.

16. No Gifts or Gratuities: Party shall not give title or possession of any thing of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Agreement.

17. Copies: All written reports prepared under this Agreement will be printed using both sides of the paper.

18. Certification Regarding Debarment: Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.

Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State's debarment list at: http://bgs.vermont.gov/purchasing/debarment

19. Certification Regarding Use of State Funds: In the case that Party is an employer and this Agreement is a State Funded Grant in excess of $1,001, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party's employee's rights with respect to unionization.

ATTACHMENT D
MODIFICATION OF CUSTOMARY PROVISIONS
OF
ATTACHMENT C OR ATTACHMENT F

1. Attachment C, Section 7 "Insurance," the paragraph titled *Professional Liability* is modified by deleting "$3,000,000 aggregate" and replacing it with "$1,000,000 aggregate."

2. Attachment C, Section 15, is modified by adding the following:

> Notwithstanding anything to the contrary in this Agreement, and with the specific intent to supersede all other provisions of this Agreement and its attachments, if the Contractor chooses to subcontract work under this Agreement, and that subcontract is "material" as defined hereinafter, the Contractor must first fill out and submit the Request for Approval to Subcontract Form (Appendix I – Required Forms) in order to seek approval from the State prior to signing an agreement with a third party. Upon receipt of the Request for Approval to Subcontract Form, the State shall review and respond within five (5) business days. The Contractor shall submit the Request for Approval to Subcontract Form to the Contract Manager:
>
> Kara Suter, MS
> Director of Payment Reform and Reimbursement
> Department of Vermont Health Access (DVHA)
> 312 Hurricane Lane
> Williston, VT 05495-2087
> 802-318-0284
>
> Should the status of any third party or Subrecipient change, the Contractor is responsible for updating the State within fourteen (14) days of said change.
>
> Contractor warrants that no data storage, processing or transfer pursuant to or in connection with this Agreement or a subcontract related to this Agreement shall occur outside the continental United States.
>
> A "material" subcontract shall be one for which the expenditure is in excess of one hundred thousand dollars ($100,000) and which relates directly to the Contractor's performance under this Agreement in fulfilling the VMSSP Standards. By way of example and not limitation, a contract relating to the printing or development of forms for Contractor would not be material, but the expenditure of $100,000 to engage case managers would be material.

3. Attachment C, Section 4 is modified by adding "and the State shall have no obligation to fund this Agreement from State revenues except as provided below in Paragraph 4A" after the word authority and before the period in the first sentence.

4. Attachment C, Section 4A is added to include 4A and 4B intended to be effective notwithstanding anything to the contrary in this Agreement, and with the specific intent to supersede the Personal Services Contract pages of this Agreement and all other provisions of all other Attachments.

4A. Inability to Fulfill Payment Provision. State will notify Contractor within 15 days of making a reasonable determination that it may not be able to fulfill the payment provisions of this contract for any reason, without regard to source of funds, and will provide a reasonable description of the basis for that determination. State will notify Contractor within 5 days of determining that it will not be able to fulfill the payment provisions of this contract for any reason, without regard to source of funds. If the State determines that it will not be able to fulfill the payment provisions of this contract, the Commissioner of DVHA or the Secretary of Administration will request sufficient funding or funding authority to fulfill the payment provisions in the next submission to the Legislature of the annual Budget Adjustment Act. The obligations of this paragraph 4A are intended to and will survive termination of this contract.

4B. State Plan Amendment(s).

(a) If State Plan Amendments sought by the State related to the VMSSP are not approved, State will immediately notify Contractor. State and Contractor will meet as soon as practical to address the continuation or conclusion of the VMSSP and fulfillment of any obligations of any Party in place at that time.

(b) In the event that Shared Savings have accrued, and a State Plan Amendment related to the VMSSP is not approved:

1. State will pay to Contractor that portion of the Shared Savings which are payable directly from State appropriations, i.e. the State share of the funding.
2. In the event that there is a failure to realize matching federal financial participation due to the denial of a State Plan Amendment related to the VMSSP State will forfeit and pay to Contractor such portion of the fifty percent (50%) of Shared Savings it would otherwise retain under this Agreement, as is required to pay Contractor the amount of Shared Savings it would have received had federal financial participation been realized. By way of example, if Shared Savings of $1,000,000 had accrued, of which $550,000 would have been federal funds and $450,000 would have been state funds when the State Plan Amendment is not approved, the Contractor would receive $450,000 in Shared Savings and the State would receive $0 in Shared Savings.
3. State's liability under this section shall not exceed the State funded portion of Shared Savings.
4. References to "State portion of Shared Savings" and "Federal portion of Shared Savings" or any references apportioning responsibility for payment of Shared Savings will be defined in accordance with Section 1905(b) of the federal Social Security Act, as clarified in the Final Federal Medical

Assistance Percentages published in the Federal Register for the relevant Performance Year quarters.

(c) In the event that there is a failure to realize federal financial participation due to the denial of a State Plan Amendment related to the VMSSP, State shall not be liable under Section 7A (Inability to Fulfill Payment Provision) of the Personal Services Contract, or under 4A (Inability to Fulfill Payment Provision) of Attachment C, as stated in Attachment D, for funds in excess of the limitation on liability stated in subsection (b)(3) of this section.

(d) The provisions of these sections 4A and 4B are intended to and shall survive termination of this Agreement.

4 The Personal Services Contract, Section 7 is modified by adding the word "materially" before the word "reduced" to the final sentence, and by adding the words "except as provided below in Paragraph 7A" after the word revenues and before the period in the last sentence.

5. The Personal Services Contract, Section 7is added to include 7A and 7B intended to be effective notwithstanding anything to the contrary in this Agreement, and with the specific intent to supersede the Personal Services Contract pages of this Agreement and all other provisions of all other Attachments.:

7A. Inability to Fulfill Payment Provision. State will notify Contractor within 15 days of making a reasonable determination that it may not be able to fulfill the payment provisions of this contract for any reason, without regard to source of funds, and will provide a reasonable description of the basis for that determination. State will notify Contractor within 5 days of determining that it will not be able to fulfill the payment provisions of this contract for any reason, without regard to source of funds. If the State determines that it will not be able to fulfill the payment provisions of this contract, the Commissioner of DVHA or the Secretary of Administration will request sufficient funding or funding authority to fulfill the payment provisions in the next submission to the Legislature of the annual Budget Adjustment Act. The obligations of this paragraph 7A are intended to and will survive termination of this contract.

7B. State Plan Amendment(s).

(a) If State Plan Amendments sought by the State related to the VMSSP are not approved, State will immediately notify Contractor. State and Contractor will meet as soon as practical to address the continuation or conclusion of the VMSSP and fulfillment of any obligations of any Party in place at that time.

(b) In the event that Shared Savings have accrued, and a State Plan Amendment related to the VMSSP is not approved:

1. State will pay to Contractor that portion of the Shared Savings which are payable directly from State appropriations, i.e. the State share of the funding.
2. In the event that there is a failure to realize matching federal financial participation due to the denial of a State Plan Amendment related to the VMSSP State will forfeit and pay to Contractor such portion of the fifty percent (50%) of Shared Savings it would otherwise retain under this Agreement, , as is required to pay Contractor the amount of Shared Savings it

would have received had federal financial participation been realized. By way of example, if Shared Savings of $1,000,000 had accrued, of which $550,000 would have been federal funds and $450,000 would have been state funds when the State Plan Amendment is not approved, the Contractor would receive $450,000 in Shared Savings and the State would receive $0 in Shared Savings.

3. State's liability under this section shall not exceed the State funded portion of Shared Savings.
4. References to "State portion of Shared Savings" and "Federal portion of Shared Savings" or any references apportioning responsibility for payment of Shared Savings will be defined in accordance with Section 1905(b) of the federal Social Security Act, as clarified in the Final Federal Medical Assistance Percentages published in the Federal Register for the relevant Performance Year quarters.

(c) In the event that there is a failure to realize federal financial participation due to the denial of a State Plan Amendment related to the VMSSP, State shall not be liable under Section 7A (Inability to Fulfill Payment Provision) of the Personal Services Contract, or under 4A (Inability to Fulfill Payment Provision) of Attachment C, as stated in Attachment D, for funds in excess of the limitation on liability stated in subsection (b)(3) of this section.

(d) The provisions of these sections 7A and 7B are intended to and shall survive termination of this Agreement.

6. Attachment F, Section 10 "Intellectual Property/Work Product Ownership" shall only be applicable to works that are specifically commissioned by the State to be developed for the use of State personnel and that are expressly intended, as evidenced by written agreement separate from Section 10, to be works for hire or to otherwise be assigned to and owned by the State. The provision shall not apply to, and the following works are not works for hire, assigned to or intended to be owned by the State:

(i) data, technical information, or any works, reports or other materials gathered, developed, originated, prepared or obtained and used by the Contractor in the conduct of its ACO activities;

(ii) data, databases, database structure or models, report formats or similar data works developed, created or used by the Contractor or its data subcontractors in the conduct of its ACO activities; or

(iii) software programs, utilities or similar technical tools developed, crated or used by the Contractor or its software system subcontractors in the conduct of its ACO activities.

APPROVAL:

E-SIGNED by Jared Bianchi on 2014-03-11 19:09:49 GMT

ASSISTANT ATTORNEY GENERAL

DATE: March 11, 2014

State of Vermont – Attachment D
Revised AHS – 12-08-09

ATTACHMENT E

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between **the State of Vermont Agency of Human Services operating by and through its Office of Vermont Heath Access** ("Covered Entity") and **Community Health Accountable Care** ("Business Associate") as of **March 14, 2014**. This Agreement supplements and is made a part of the Contract to which it is an attachment.

Covered Entity and Business Associate enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 ("Privacy Rule"), and the Security Standards, at 45 CFR Parts 160 and 164 ("Security Rule"), as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH), and any associated federal rules and regulations.

The parties agree as follows:

1. Definitions. All capitalized terms used but not otherwise defined in this Agreement have the meanings set forth in 45 CFR Parts 160 and 164 as amended by HITECH and associated federal rules and regulations.

"Agent" means those person(s) who are agents(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

"Breach" means the acquisition, access, use or disclosure of protected health information (PHI) which compromises the security or privacy of the PHI, except as excluded in the definition of Breach in 45 CFR § 164.402.

"Business Associate shall have the meaning given in 45 CFR § 160.103.

"Individual" includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

"Protected Health Information" or PHI shall have the meaning given in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Agency.

"Security Incident" means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

"Services" includes all work performed by the Business Associate for or on behalf of Covered Entity that requires the use and/or disclosure of protected health information to perform a business associate function described in 45 CFR § 160.103 under the definition of Business Associate.

"Subcontractor" means a person or organization to whom a Business Associate delegates a function, activity or service, other than in the capacity of a member of the workforce of the Business Associate. For purposes of this Agreement, the term Subcontractor includes Subgrantees.

2. Identification and Disclosure of Privacy and Security Offices. Business Associate and Subcontractors shall provide, within ten (10) days of the execution of this agreement, written notice to the Covered Entity's contract/grant manager the names and contact information of both the HIPAA Privacy Officer and HIPAA Security Officer. This information must be updated any time either of these contacts changes.

3. Permitted and Required Uses/Disclosures of PHI.

3.1 Except as limited in this Agreement, Business Associate may use or disclose PHI to perform Services, as specified in the underlying grant or contract with Covered Entity. The uses and disclosures of Business Associate are limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the underlying agreement. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

3.2 Business Associate may make PHI available to its employees who need access to perform Services provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with such restrictions. Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents and Subcontractors in accordance with Sections 9 and 17 or, (b) as otherwise permitted by Section 3.

3.3 Business Associate shall be directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Covered Entity, and for impermissible uses and disclosures, by Business Associate's Subcontractor(s), of the PHI that Business Associate handles on behalf of Covered Entity and that it passes on to Subcontractors.

4. Business Activities. Business Associate may use PHI received in its capacity as a Business Associate to Covered Entity if necessary for Business Associate's proper management and administration or to carry out its legal responsibilities. Business Associate may disclose PHI received in its capacity as Business Associate to Covered Entity for Business Associate's proper management and administration or to carry out its legal responsibilities if a disclosure is Required by Law or if Business Associate obtains reasonable written assurances via a written agreement from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the Agreement requires the person or entity to notify Business Associate, within two (2) business days (who in turn will notify Covered Entity within two (2) business days after receiving notice of a Breach as specified in Section 6.1), in writing of

any Breach of Unsecured PHI of which it is aware. Uses and disclosures of PHI for the purposes identified in Section 3 must be of the minimum amount of PHI necessary to accomplish such purposes.

5. Safeguards. Business Associate, its Agent(s) and Subcontractor(s) shall implement and use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement. With respect to any PHI that is maintained in or transmitted by electronic media, Business Associate or its Subcontractor(s) shall comply with 45 CFR sections 164.308 (administrative safeguards), 164.310 (physical safeguards), 164.312 (technical safeguards) and 164.316 (policies and procedures and documentation requirements). Business Associate or its Agent(s) and Subcontractor(s) shall identify in writing upon request from Covered Entity all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.

6. Documenting and Reporting Breaches.

6.1 Business Associate shall report to Covered Entity any Breach of Unsecured PHI, including Breaches reported to it by a Subcontractor, as soon as it (or any of its employees or agents) becomes aware of any such Breach, and in no case later than two (2) business days after it (or any of its employees or agents) becomes aware of the Breach, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

6.2 Business Associate shall provide Covered Entity with the names of the individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR § 164.404(c), and, if requested by Covered Entity, information necessary for Covered Entity to investigate the impermissible use or disclosure. Business Associate shall continue to provide to Covered Entity information concerning the Breach as it becomes available to it. Business Associate shall require its Subcontractor(s) to agree to these same terms and conditions.

6.3 When Business Associate determines that an impermissible acquisition, use or disclosure of PHI by a member of its workforce is not a Breach, as that term is defined in 45 CFR § 164.402, and therefore does not necessitate notice to the impacted individual(s), it shall document its assessment of risk, conducted as set forth in 45 CFR § 402(2). When requested by Covered Entity, Business Associate shall make its risk assessments available to Covered Entity. It shall also provide Covered Entity with 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low probability that the PHI had been compromised. When a breach is the responsibility of a member of its Subcontractor's workforce, Business Associate shall either 1) conduct its own risk assessment and draft a summary of the event and assessment or 2) require its Subcontractor to conduct the assessment and draft a summary of the event. In either case, Business Associate shall make these assessments and reports available to Covered Entity.

6.4 Business Associate shall require, by contract, a Subcontractor to report to Business Associate and Covered Entity any Breach of which the Subcontractor becomes aware, no later than two (2) business days after becomes aware of the Breach.

7. Mitigation and Corrective Action. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible use or disclosure of PHI, even if the impermissible use or disclosure does not constitute a Breach. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by Covered Entity, Business Associate shall make its mitigation and corrective action plans available to Covered Entity. Business Associate shall require a Subcontractor to agree to these same terms and conditions.

8. Providing Notice of Breaches.

8.1 If Covered Entity determines that an impermissible acquisition, access, use or disclosure of PHI for which one of Business Associate's employees or agents was responsible constitutes a Breach as defined in 45 CFR § 164.402, and if requested by Covered Entity, Business Associate shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When requested to provide notice, Business Associate shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate.

8.2 If Covered Entity or Business Associate determines that an impermissible acquisition, access, use or disclosure of PHI by a Subcontractor of Business Associate constitutes a Breach as defined in 45 CFR § 164.402, and if requested by Covered Entity or Business Associate, Subcontractor shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When Covered Entity requests that Business Associate or its Subcontractor provide notice, Business Associate shall either 1) consult with Covered Entity about the specifics of the notice as set forth in section 8.1, above, or 2) require, by contract, its Subcontractor to consult with Covered Entity about the specifics of the notice as set forth in section 8.1

8.3 The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to Covered Entity.

8.4 The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of what happened, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 CFR § 164.404(c).

8.5 Business Associate shall notify individuals of Breaches as specified in 45 CFR § 164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of Vermont, Business Associate shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR § 164.406.

9. **Agreements with Subcontractors**. Business Associate shall enter into a Business Associate Agreement with any Subcontractor to whom it provides PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity in which the Subcontractor agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI. Business Associate must enter into this Business Associate Agreement before any use by or disclosure of PHI to such agent. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of PHI. Business Associate shall provide a copy of the Business Associate Agreement it enters into with a subcontractor to Covered Entity upon request. Business associate may not make any disclosure of PHI to any Subcontractor without prior written consent of Covered Entity.

10. **Access to PHI**. Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or as directed by Covered Entity to an Individual to meet the requirements under 45 CFR § 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.

11. **Amendment of PHI**. Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.

12. **Accounting of Disclosures**. Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Business Associate shall provide such information to Covered Entity or as directed by Covered Entity to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.

13. **Books and Records**. Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity available to the Secretary

in the time and manner designated by the Secretary. Business Associate shall make the same information available to Covered Entity, upon Covered Entity's request, in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.

14. Termination.

14.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all of the PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity is destroyed or returned to Covered Entity subject to Section 18.7.

14.2 If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide an opportunity for Business Associate to cure the breach and Covered Entity may terminate the contract or grant without liability or penalty if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate the contract or grant without liability or penalty if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under the contract or grant, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

15. Return/Destruction of PHI.

15.1 Business Associate in connection with the expiration or termination of the contract or grant shall return or destroy, at the discretion of the Covered Entity, all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity pursuant to this contract or grant that Business Associate still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of the PHI. Business Associate shall certify in writing for Covered Entity (1) when all PHI has been returned or destroyed and (2) that Business Associate does not continue to maintain any PHI. Business Associate is to provide this certification during this thirty (30) day period.

15.2 Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible for so long as Business Associate maintains such PHI. This shall also apply to all Agents and Subcontractors of Business Associate.

16. Penalties and Training. Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory,

accreditation, and licensure organizations. If requested by Covered Entity, Business Associate shall participate in training regarding the use, confidentiality, and security of PHI.

17. Security Rule Obligations. The following provisions of this section apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.

17.1 Business Associate shall implement and use administrative, physical, and technical safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312 with respect to the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to protect such Electronic PHI.

17.2 Business Associate shall ensure that any Agent and Subcontractor to whom it provides Electronic PHI agrees in a written agreement to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into this written agreement before any use or disclosure of Electronic PHI by such Agent or Subcontractor. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of Electronic PHI. Business Associate shall provide a copy of the written agreement to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any Agent or Subcontractor without the prior written consent of Covered Entity.

17.3 Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an Agent or Subcontractor). Business Associate shall provide this written report as soon as it becomes aware of any such Security Incident, and in no case later than two (2) business days after it becomes aware of the incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

17.4 Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

18. Miscellaneous.

18.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the contract/grant, the terms of this Agreement shall govern with respect to its subject matter. Otherwise, the terms of the contract/grant continue in effect.

18.2 Business Associate shall cooperate with Covered Entity to amend this Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

18.3 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

18.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule, and the HIPAA omnibus final rule) in construing the meaning and effect of this Agreement.

18.5 As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity.

18.6 Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity or creates or receives on behalf of Covered Entity even if some of that information relates to specific services for which Business Associate may not be a "Business Associate" of Covered Entity under the Privacy Rule.

18.7 Business Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI. Business Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

18.8 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for Business Associate to return or destroy PHI as provided in Section 14.2 and (b) the obligation of Business Associate to provide an accounting of disclosures as set forth in Section 11 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

ATTACHMENT F
AGENCY OF HUMAN SERVICES' CUSTOMARY CONTRACT PROVISIONS

1. **Agency of Human Services – Field Services Directors** will share oversight with the department (or field office) that is a party to the contract for provider performance using outcomes, processes, terms and conditions agreed to under this contract.

2. **2-1-1 Data Base:** The Contractor providing a health or human services within Vermont, or near the border that is readily accessible to residents of Vermont, will provide relevant descriptive information regarding its agency, programs and/or contact and will adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211. If included, the Contractor will provide accurate and up to date information to their data base as needed. The "Inclusion/Exclusion" policy can be found at www.vermont211.org

3. **Medicaid Program Contractors**:

   Inspection of Records: Any contracts accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid program must fulfill state and federal legal requirements to enable the Agency of Human Services (AHS), the United States Department of Health and Human Services (DHHS) and the Government Accounting Office (GAO) to:

   Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and Inspect and audit any financial records of such Contractor or subcontractor.

   Subcontracting for Medicaid Services: Having a subcontract does not terminate the Contractor, receiving funds under Vermont's Medicaid program, from its responsibility to ensure that all activities under this agreement are carried out. Subcontracts must specify the activities and reporting responsibilities of the Contractor or subcontractor and provide for revoking delegation or imposing other sanctions if the Contractor or subcontractor's performance is inadequate. The Contractor agrees to make available upon request to the Agency of Human Services; the Department of Vermont Health Access; the Department of Disabilities, Aging and Independent Living; and the Center for Medicare and Medicaid Services (CMS) all contracts and subcontracts between the Contractor and service providers.

   Medicaid Notification of Termination Requirements: Any Contractor accessing payments for services under the Global Commitment to Health Waiver and Medicaid programs who terminates their practice will follow the Department of Vermont Health Access, Managed Care Organization enrollee notification requirements.

   Encounter Data: Any Contractor accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid programs must provide encounter data to the Agency of Human Services and/or its departments and ensure that it can be linked to enrollee eligibility files maintained by the State.

   Federal Medicaid System Security Requirements Compliance: All contractors and subcontractors must provide a security plan, risk assessment, and security controls review document within three months of the start date of this agreement (and update it annually

thereafter) to support audit compliance with 45CFR95.621 subpart F, *ADP* (Automated Data Processing) *System Security Requirements and Review Process.*

4. **Non-discrimination Based on National Origin as evidenced by Limited English Proficiency**. The Contractor agrees to comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, which require that contractors and subcontractors receiving federal funds must assure that persons with limited English proficiency can meaningfully access services. To the extent the Contractor provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services in compliance with this requirement, such individuals cannot be required to pay for such services.

5. **Voter Registration**. When designated by the Secretary of State, the Contractor agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of state and federal law pertaining to such agencies.

6. **Drug Free Workplace Act.** The Contractor will assure a drug-free workplace in accordance with 45 CFR Part 76.

7. **Privacy and Security Standards.**

   Protected Health Information: The Contractor shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this contract. The Contractor shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations.

   Substance Abuse Treatment Information: The confidentiality of any alcohol and drug abuse treatment information acquired by or provided to the Contractor or subcontractor shall be maintained in compliance with any applicable state or federal laws or regulations and specifically set out in 42 CFR Part 2.

   Other Confidential Consumer Information: The Contractor agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to information. The Contractor agrees to comply with any applicable Vermont State Statute, including but not limited to 12 VSA §1612 and any applicable Board of Health confidentiality regulations. The Contractor shall ensure that all of its employees and subcontractors performing services under this agreement understand the sensitive nature of the information that they may have access to and sign an affirmation of understanding regarding the information's confidential and non-public nature.

   Social Security numbers: The Contractor agrees to comply with all applicable Vermont State Statutes to assure protection and security of personal information, including protection from identity theft as outlined in Title 9, Vermont Statutes Annotated, Ch. 62.

8. **Abuse Registry.** The Contractor agrees not to employ any individual, use any volunteer, or otherwise provide reimbursement to any individual in the performance of services connected with this agreement, who provides care, custody, treatment, transportation, or supervision to children or vulnerable adults if there is a substantiation of abuse or neglect or exploitation against that individual. The Contractor will check the Adult Abuse Registry in the Department

of Disabilities, Aging and Independent Living. Unless the Contractor holds a valid child care license or registration from the Division of Child Development, Department for Children and Families, the Contractor shall also check the Central Child Protection Registry. (See 33 V.S.A. §4919(a)(3) & 33 V.S.A. §6911(c)(3)).

9. **Reporting of Abuse, Neglect, or Exploitation.** Consistent with provisions of 33 V.S.A. §4913(a) and §6903, any agent or employee of a Contractor who, in the performance of services connected with this agreement, has contact with clients or is a caregiver and who has reasonable cause to believe that a child or vulnerable adult has been abused or neglected as defined in Chapter 49 or abused, neglected, or exploited as defined in Chapter 69 of Title 33 V.S.A. shall make a report involving children to the Commissioner of the Department for Children and Families within 24 hours or a report involving vulnerable adults to the Division of Licensing and Protection at the Department of Disabilities, Aging, and Independent Living within 48 hours. This requirement applies except in those instances where particular roles and functions are exempt from reporting under state and federal law. Reports involving children shall contain the information required by 33 V.S.A. §4914. Reports involving vulnerable adults shall contain the information required by 33 V.S.A. §6904. The Contractor will ensure that its agents or employees receive training on the reporting of abuse or neglect to children and abuse, neglect or exploitation of vulnerable adults.

10. **Intellectual Property/Work Product Ownership.** All data, technical information, materials first gathered, originated, developed, prepared, or obtained as a condition of this agreement and used in the performance of this agreement - including, but not limited to all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video or audio**)**, pictures, drawings, analyses, graphic representations, software computer programs and accompanying documentation and printouts, notes and memoranda, written procedures and documents, which are prepared for or obtained specifically for this agreement - or are a result of the services required under this grant - shall be considered "work for hire" and remain the property of the State of Vermont, regardless of the state of completion - unless otherwise specified in this agreement. Such items shall be delivered to the State of Vermont upon 30 days notice by the State. With respect to software computer programs and / or source codes first developed for the State, all the work shall be considered "work for hire," i.e., the State, not the Contractor or subcontractor, shall have full and complete ownership of all software computer programs, documentation and/or source codes developed.

    The Contractor shall not sell or copyright a work product or item produced under this agreement without explicit permission from the State.

    If the Contractor is operating a system or application on behalf of the State of Vermont, then the Contractor shall not make information entered into the system or application available for uses by any other party than the State of Vermont, without prior authorization by the State. Nothing herein shall entitle the State to pre-existing Contractor's materials.

11. **Security and Data Transfers.** The State shall work with the Contractor to ensure compliance with all applicable State and Agency of Human Services' policies and standards, especially those related to privacy and security. The State will advise the Contractor of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Contractor to implement any required.

The Contractor will ensure the physical and data security associated with computer equipment - including desktops, notebooks, and other portable devices - used in connection with this agreement. The Contractor will also assure that any media or mechanism used to store or transfer data to or from the State includes industry standard security mechanisms such as continually up-to-date malware protection and encryption. The Contractor will make every reasonable effort to ensure media or data files transferred to the State are virus and spyware free. At the conclusion of this agreement and after successful delivery of the data to the State, the Contractor shall securely delete data (including archival backups) from the Contractor's equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

12. **Computing and Communication:** The Contractor shall select, in consultation with the Agency of Human Services' Information Technology unit, one of the approved methods for secure access to the State's systems and data, if required. Approved methods are based on the type of work performed by the Contractor as part of this agreement. Options include, but are not limited to:

    1. Contractor's provision of certified computing equipment, peripherals and mobile devices, on a separate Contractor's network with separate internet access. The Agency of Human Services' accounts may or may not be provided.

    2. State supplied and managed equipment and accounts to access state applications and data, including State issued active directory accounts and application specific accounts, which follow the National Institutes of Standards and Technology (NIST) security and the Health Insurance Portability & Accountability Act (HIPAA) standards.

    The State will not supply e-mail accounts to the Contractor.

13. **Lobbying.** No federal funds under this agreement may be used to influence or attempt to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendments other than federal appropriated funds.

14. **Non–discrimination.** The Contractor will prohibit discrimination on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, or on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. No person shall on the grounds of sex (including, in the case of a woman, on the grounds that the woman is pregnant) or on the grounds of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination, to include sexual harassment, under any program or activity supported by state and/or federal funds.

    The Contractor will also not refuse, withhold from or deny to any person the benefit of services, facilities, goods, privileges, advantages, or benefits of public accommodation on the basis of disability, race, creed, color, national origin, marital status, sex, sexual orientation or gender identity under Title 9 V.S.A. Chapter 139.

15. **Environmental Tobacco Smoke.** Public Law 103-227, also known as the Pro-children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility

owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, child care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds.

The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

Contractors are prohibited from promoting the use of tobacco products for all clients. Facilities supported by state and federal funds are prohibited from making tobacco products available to minors.

Attachment F - Revised AHS -12/10/10

ATTACHMENT G - APPENDIX 1
Department of Vermont Health Access
Request for Approval to Subcontract

Original Grantee Name: _____ Contract #: _____

Address: _____

Phone Number: _____

Contact Person: _____

Agreement #: _____ Signature:_____

Subcontractor Name: _____

Address: _____

Phone Number: _____

Contact Person: _____

Scope of Subcontracted Services: _____

Is any portion of the work being outsourced outside of the United States? YES NO
(Note to Business Office: If Yes, do not proceed further with approval until reviewed with Finance & Mgmt)

Dollar Amount of Subcontracted Services: $ _____

Date Range for Subcontracted Services: Start: _____ End: _____

DVHA Program Manager: _____ **Signature:**_____

Phone Number: _____

Business Office Review Comments: _____

Approval: _____ Title: _____ Date: _____

ATTACHMENT H
Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) Adjustment

1. The method of the adjustment is as follows:

2. Using historic cost per encounter data from 2010-2012 either from settled or filed cost reports, a Cumulative Average Growth Rate (CAGR) will be calculated for each FQHC and RHC. The CAGR will be used to adjust the most recent cost per encounter to the 2014 Performance Year. This cost per encounter will be substituted in both the actual and expected cost calculations in lieu of the Medicaid capped amount.

3. Currently available historic, CAGR and estimated 2014 cost per encounter data is below. Note however, the final adjustment will be done using the most recently available data as of December 31 in the performance year.

Provider Name	Provider Type	2010 Date	2011 Date	2012 Date	2013 Date	2014 Date	CAGR
Ammonoosuc Community Health Service	FQHC	6/30/2010 0:00	6/30/2011 0:00	6/30/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter		$ 177.00	$ 184.72	$ 188.41	$ 192.37	$ 196.41	2.10%
Comments		settled	settled	submitted			
Cold Hollow Family Practice		12/31/2010 0:00	12/31/2011 0:00	12/31/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter	RHC	$ 90.14	$ 87.86	$ 93.02	$ 94.00	$ 94.98	1.05%
Comments		NGS settled	settled	submitted			
Community Health Center of Burlington V	FQHC	4/30/2010 0:00	4/30/2011 0:00	4/30/2012 0:00	4/30/2013 0:00	estimate 2014	
Historical Cost Per Encounter		$ 167.93	$ 152.93	$ 161.15	$ 167.67	$ 167.60	-0.04%
Comments		settled	settled	submitted	submitted		
Community Health Centers of the Rutlanc	FQHC	12/31/2010 0:00	12/31/2011 0:00	12/31/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter		$ 120.17	$ 123.09	$ 135.12	$ 140.51	$ 146.12	3.99%
Comments		settled	settled	submitted			
Copley Professional Services Group	FQHC	9/30/2010 0:00	9/30/2011 0:00	9/30/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter		$ 145.30	$ 134.33	$ 162.15	$ 168.20	$ 174.47	3.73%
Comments		settled	settled	submitted			
David W Hobbs, MD - Keeler Bay	RHC	12/31/2010 0:00	12/31/2011 0:00	12/31/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter		$ 99.40		$ 85.60	$ 81.44	$ 77.48	-4.86%
Comments		NGS settled	CR not filed on the	submitted			
Indian Stream/Colebrook	FQHC	6/30/2010 0:00	6/30/2011 0:00	6/30/2012 0:00	12/31/2012 0:00	estimate 2014	
Historical Cost Per Encounter		$ 210.32	$ 188.13	$ 190.55	$ 227.38	$ 231.86	1.97%
Comments		settled	submitted	submitted	submitted		
Little Rivers Health Care	FQHC	12/31/2010 0:00	12/31/2011 0:00	12/31/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter		$ 153.38	$ 175.29	$ 208.27	$ 230.64	$ 255.41	10.74%
Comments		settled	settled	submitted			
Michael Welther, MD Arlington Family Pr	RHC		12/31/2011 0:00	12/31/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter			$ 79.90	$ 89.60	$ 94.89	$ 100.48	5.90%
Comments			settled	submitted			
Mountain Valley Health Council	RHC		12/31/2011 0:00	12/31/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter			$ 155.47	$ 183.36	$ 199.13	$ 216.25	8.60%
Comments			settled	submitted			
NE Washington County Comm Health Ce	FQHC	6/30/2010 0:00	6/30/2011 0:00	6/30/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter		$ 137.98	$ 151.64	$ 157.94	$ 165.22	$ 172.84	4.61%
Comments		settled	settled	submitted			
Newport Pediatrics & Adolescent Medicir	RHC		12/31/2011 0:00	12/31/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter			$ 97.18	$ 119.71	$ 132.87	$ 147.47	10.99%
Comments			settled	submitted			
Northern Counties Health Care	FQHC	3/31/2010 0:00	3/31/2011 0:00	3/31/2012 0:00	3/31/2013 0:00	estimate 2014	
Historical Cost Per Encounter		$ 143.50	$ 162.46	$ 158.89	$ 179.47	$ 189.79	5.75%
Comments		settled**	settled	submitted	submitted		
Richford Health Center	FQHC	12/31/2010 0:00	12/31/2011 0:00	12/31/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter		$ 163.07	$ 164.30	$ 166.67	$ 167.89	$ 169.11	0.73%
Comments		settled	settled	submitted			
Ryder Brook Pediatrics	RHC		12/31/2011 0:00	12/31/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter			$ 86.28	$ 103.21	$ 112.88	$ 123.46	9.37%
Comments			settled	submitted			
Springfield Medical Care Systems, Inc.	FQHC	9/30/2010 0:00	9/30/2011 0:00	9/30/2012 0:00	estimate 2013	estimate 2014	
Historical Cost Per Encounter		$ 141.36	$ 148.51	$ 149.19	$ 151.89	$ 154.64	1.81%
Comments		NGS settled	settled	submitted			
Submitted - data taken from submitted cost reports							
Settled - data taken from settlement enclosure of MSLC issued settlement							
NGS Settleed - data taken from NGS settlement							

Attachment H Table 1

ATTACHMENT I
SERVICES CONSIDERED IN ELIGIBLE INDIVIDUAL ATTRIBUTION METHODOLOGY, STEP 2

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization

CPT-4 Code Description Summary
of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner • HCPCS T1015